



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DALLAS COUNTY HOSPITAL

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-1288-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was processed by TEXAS MUTUAL on the date of 6/10/2014. However, reimbursement was denied with the rationale: THE TIME LIMIT FOR FILING HAS EXPIRED. Regarding this denial DALLAS COUNTY HOSPITAL would show the following:

1. The claimant presented at and was treated by the DALLAS COUNTY HOSPITAL on the date of 1/08/2013-1/11/2013. At that time, hospital staff did not obtain information stating that this was related to an on the job injury.
2. The charges were billed to UHC and subsequently a payment was issued on the account."

Amount in Dispute: \$43,259.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute 1/8/2013 to 1/11/2013 ... One year from disputed 1/11/13 is 1/11/14. The TDI/DWC date stamp lists the received date as 12/29/14 on the requestor's DWC-60 packet, a date greater than one year from 1/11/13. The requestor has waived its right to DWC MDR.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 08, 2013 to January 11, 2013	Inpatient Hospital Services	\$43,259.66	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-29 – The time limit for filing has expired

- 731 – Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/05

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is January 08, 2013 to January 11, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 29, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	3/13/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.